Your Anthem Benefits

Anthem®

State of Indiana Benefits Comparison
Summary of Benefits for 2009

	HIGH DEDUCTIBLE HEALTH PLAN 1	HIGH DEDUDUCTIBLE HEALTH PLAN 2	TRADITIONAL PLAN II
Deductible (Single/Family) Deductibles are co-mingled Network and Non-network	$ 2,500 single Network/Non-network $ 5,000 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan. **<u>With Tobacco Incentive:</u>** $ 2,000 single Network/Non-network $ 4,500 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.	$ 1,700 single Network/Non-network $ 3,400 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan. **<u>With Tobacco Incentive:</u>** $ 1,200 single Network/Non-network $ 2,900 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.	$500 single Network/Non-network $500 family Network/Non-network (Applies only to percent (%) coinsurance) **Deductible applies to Prescription Drugs** **<u>With Tobacco Incentive</u>**: $0 single Network/Non-network $0 family Network/Non-network
Out of Pocket Maximum (Single/Family) Out of pockets are co-mingled Network and Non-network	$4,000 single coverage $8,000 family coverage The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible	$2,400 single coverage $4,800 family coverage The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible	$2,000 per enrollee $4,000 per family Includes the deductible Rx copay(s) <u>do not</u> accrue to the out of pocket maximum
	<u>Note:</u> The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.	**<u>Note:</u>** The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.	**<u>Note:</u>** The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.

	HIGH DEDUCTIBLE HEALTH PLAN 1	HIGH DEDUDUCTIBLE HEALTH PLAN 2	TRADITIONAL PLAN II
Professional Office Services **Including allergy** – testing and treatment – serum and injections	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit	$20 Network/40% Non-network per visit
Preventative Care Services Services include: Immunizations for eligible dependents, annual physicals, flu shots, annual pap smears and diagnostic services performed with the annual physical. This benefit does not include inpatient services or surgical procedures.	**Covered In Full Network**/40% Non-network In-Network is Not subject to deductible	**Covered In Full Network**/40% Non-network In-Network is Not subject to deductible	$20 Office Visit Co pay Network/ 40% Non-network
Medical Supplies, Equipment & Appliances	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network **Subject to deductible**
Maternity Services	20% Network/40% Non-network	20% Network/40% Non-network	$500 Network/40% Non-network
Inpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	$500 Network/40% Non-network
Outpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	$250 Network/40% Non-network
Professional Inpatient/Outpatient Services	20% Network/40% Non-network	20% Network/40% Non-network	Covered in full after deductible Network/40% Non-network **Subject to deductible**
Emergency and Urgent Care: • Emergency Care in ER Room • Urgent Care Facility	20% Network/20% Non-network	20% Network/20% Non-network	$75 Network or Non-network $35 Network or Non-network
Ambulance	20% Network/20% Non-network	20% Network/20% Non-network	$50 Network or Non-network
Radiation/Inhalation Therapy	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Copay Network/ 40% Non-network
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Copay Network/ 40% Non-network

	HIGH DEDUCTIBLE HEALTH PLAN 1	HIGH DEDUDUCTIBLE HEALTH PLAN 2	TRADITIONAL PLAN II
Mammogram Includes 1 per person, per calendar year. **Routine Prostate Antigen Tests (PSA**) Includes 1 per person, per calendar year **Colorectal Cancer Exam/Laboratory Testing**	Covered in full Network/40% Non-network Not subject to deductible Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy and screening colonoscopy	Covered in full Network/40% Non-network Not subject to deductible Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy and screening colonoscopy	$20 Office Visit Copay Network/ 40% Non-network Includes fecal occult blood test, barium enema, and flexible sigmoidoscopy performed at a physician's office.
Diabetes Self Management Training	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Copay Network/ 40% Non-network
Diagnostic Services (i.e. lab, x-ray, MRI)	20% Network/40% Non-network	20% Network/40% Non-network	Covered in full after deductible Network/ 40% Non-network **Subject to deductible**
Temporomandibular Joint (TMJ) Services • Outpatient Facility • Provider Individual • TMJ Surgery - Professional Services	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)	 $250 Copay Network/40% Non-network $20 OV Copay Network/40%Non-network Covered in full after deductible/ 40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)
Hospice	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network **Subject to deductible**
Home Health Care No RN/LPN unless billed through a Home Health Care Agency	20% Network/40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee	20% Network/40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee	$20 Copay per day Network/ 40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee
Home IV Therapy	20% Network/40% Non-network	20% Network/40% Non-network	$20 Copay per day Network/ 40% Non-network

	HIGH DEDUCTIBLE HEALTH PLAN 1	HIGH DEDUCTIBLE HEALTH PLAN 2	TRADITIONAL PLAN II
Managed Mental Health including Substance Abuse	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	$500 Inpatient Copay Network/ 40% Non-network $20 Office Visit Copay Network/ 40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.
Human Organ and Tissue Transplants (HOTT) Specialty Network	20% Network/40% Non-network See contract for other maximums and exclusions	20% Network/40% Non-network See contract for other maximums and exclusions	$2,000 Network/40% Non-network See contract for other maximums and exclusions
Lifetime Maximum includes Human Organ and Tissue Transplants (HOTT)	$2 million Network and Non-network combined	$2 million Network and Non-network combined	$2 million
Prescription Drug Options: **Network Tier structure equals 1/2/3 (and 4, if applicable)** Including Birth Control **Network Retail Pharmacies:**	**Network** / **Non-network**	**Network** / **Non-network**	**Network** / **Non-network** **Deductible applies** Co-pays apply after deductible satisfied
	Tier 1 10% 40% Tier 2 20% 40% Tier 3 & 4 40% 40%	Tier 1 10% 40% Tier 2 20% 40% Tier 3 & 4 40% 40%	Tier 1 $10 40% Tier 2 $20 40% Tier 3 & 4 40% 40% (min.$40; max.$100)
Anthem Rx Direct Mail Service: The network penalty will be waived if there is not a network pharmacy within 12 miles of the participant's home. Tier 1 – Preferred Prescription Drugs (Generic) Tier 2 – Preferred Prescription Drug (Formulary Brand) Tier 3 - Non-Preferred Prescription Drug (Non-formulary Brand) Tier 4 – Prescription Drugs (Mostly injectable drugs)	Tier 1 10% Not covered Tier 2 20% Tier 3 & 4 40% Not covered **Network Retail Pharmacies:** up to a 34-days supply of medication or 100 units **Anthem Rx Direct Mail Service:** up to a 90 day supply	Tier 1 10% Not covered Tier 2 20% Tier 3 & 4 40% Not covered **Network Retail Pharmacies:** up to a 34-days supply of medication or 100 units **Anthem Rx Direct Mail Service:** up to a 90 day supply	Tier 1 $20 Not covered Tier 2 $40 Tier 3 & 4 40% Not covered (min.$80; max. $150) **The prescription drug copays do not apply to the medical out of pocket.** **Network Retail Pharmacies:** 100% of allowable cost after copayment up to a maximum of 34-days supply of medication or 100 units **Anthem Rx Direct Mail Service:** 100% of allowable cost after copayment up to a maximum 90 day supply

See Benefit Booklet for exclusions

Notes:

- Dependent age: to end of the calendar year after the child's 19th birthday; or to the end of the calendar year after the child's 23rd birthday if the Dependent qualifies as a Full Time Student.
- No deductible carry over credit
- All out-of-network charges that require a 40% co-insurance are subject to the deductible.

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.